



Epidemiological Considerations Working with Culturally Diverse Populations

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James¹ is a 29-year-old Afro-Latino, Christian male who identifies as cis-gendered and bisexual. His parents are monolingual Spanish speaking and are members of the working poor class. He is a second-generation immigrant who grew up speaking English and Spanish in his home. James is a member of the upper middle class and works in the financial services industry as an analyst. He reports feeling depressed (low mood, anhedonia, and irritability) as well as having some unusual perceptual experiences.

Clinicians are used to treating individuals like *James* who present with rich backgrounds, a mixture of group identities, and psychological distress and symptoms. While clinical training often emphasizes the individual-level analysis of symptomatology, individuals also hold group identities situated in communities that correspond to varying structures within the greater society. Accordingly, population-level risk factors are associated with these group identities

¹James is a completely fictitious person created for illustrative purposes.

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that often shape the day-to-day experiences of individuals (e.g., probability of experiencing racial microaggressions; exposure to adversity). This chapter describes some of these epidemiological factors to consider when working with diverse groups of clients like James.

Theoretical Models of Risk: Socioeconomic Status and Race

Social causation and social selection are two theoretical mechanisms proposed in epidemiological literature to explain why membership to group identities that experience adversity is associated with mental health clinical outcomes (Dohrenwend et al., 1992). The theory of social causation predicts that the adversity and life stress experienced by disadvantaged ethnic groups of low SES leads to higher rates of psychopathology compared to higher SES groups. Consequently, groups with lower socioeconomic status (SES) are more vulnerable to mental illness illustrating the inverse relationship that exists between psychiatric disorders and SES (Dohrenwend et al., 1992). In contrast, social selection predicts that having mental illness limits social mobility, access to resources, and occupational attainment. As a result, offspring of affected individuals, who are genetically more at risk for their parental disorders, are born into a lower status thereby limiting

income and continuing their downward drift. In this situation, the social adversity does not cause stress and subsequent mental disorder, rather, genetic vulnerability creates the association between mental illness and low SES.

Bruce Dohrenwend and colleagues' groundbreaking Science article in 1992 put these mechanisms to the test using an Israeli birth cohort study of 4914 respondents, in which the prevalence of psychiatric disorders was compared across four groups: high SES racial minority, high SES racial majority, low SES racial minority, and low SES racial majority. Dohrenwend et al. (1992) tested this classical epidemiological issue by focusing on ethnic status in relation to SES. Because of ethnic prejudice and discrimination, members of disadvantaged ethnic groups are more likely to experience barriers against achieving highly valued goals (Dohrenwend et al., 1992). These barriers, which restrict mobility opportunities, affect disadvantaged ethnic groups at every level of SES. Dohrenwend et al. (1992) found that for most mental health disorders studied, specifically depression, substance use, and anti-social personality disorder, social causation factors were dominant. These disorders were significantly higher among the racially disadvantaged low SES groups.

In contrast, they found that social selection mechanisms may explain the relation between low SES and mental disorders, specifically for schizophrenia (Dohrenwend et al., 1992). When social selection causal mechanisms are operating, the rates of disorder among the high SES group should be lower for racially disadvantaged groups compared to racially advantaged groups because the more advantaged ethnic group will be more likely to be able to support unhealthy individuals at higher SES levels and only the healthy racially disadvantaged individuals would be able to endure discrimination and rise to and/or maintain their high SES.

Recent epidemiological studies provide evidence that supports social causation (van Os & McGuffin, 2003). The theory not only explains the relationships between SES, race, and health, but it also identifies the role racial discrimination

plays in these relationships. Colen, Ramey, Cooksey, and Williams (2017) analyzed a nationally representative sample of longitudinal data collected over a 33-year time span to assess the relationship between socioeconomic mobility, exposure to discrimination, and self-rated health in African Americans, Latinos, and Whites. Despite all three groups having access to above average social and economic resources, nonpoor African Americans and Latinos reported significantly worse health compared to nonpoor Whites. The results also showed a key difference in the association between SES and unfair treatment across race. Moderate income gains for Whites over time resulted in significantly less exposure to both acute and chronic discrimination. African Americans, on the other hand, did not reap the same benefit from upward mobility. African Americans whose incomes moderately increased over time were significantly more likely to experience acute discrimination and just as likely to experience chronic discrimination compared to their socioeconomically stable counterparts. For African Americans, acute experiences of racial discrimination may attenuate the health benefits of having more socioeconomic resources. These findings support an increasing body of research that argues that the meaning of SES, and the relationship between SES and health differs based on racial status in part due to racial discrimination (Colen et al., 2017).

When unfair treatment is experienced as a psychosocial threat, a stress response is activated via the hypothalamic-pituitary-adrenal axis (HPA axis). When the HPA axis is activated, a mixture of hormones that include cortisol and epinephrine are released that trigger a cascade of physiological stress responses in the body (Cohen et al., 2006; Cunningham et al., 2012). These responses include increased heart rate, elevated blood pressure, and respiration. Health outcomes are worse for those who repeatedly experience this stress response and those who cannot turn off this physiological cascade once it is activated (Schneiderman, Ironson, & Siegel, 2005).

Racial discrimination can be chronic, where there are enduring and recurrent exposures that

persist over long spans of time (Ong, Fuller-Rowell, & Burrow, 2009). An example of chronic racial discrimination is being talked down to by teachers and later colleagues or being ignored or not trusted to have knowledge. Racial discrimination can also be daily, where the experience has a discrete onset and end. An example of daily racial discrimination is getting stared at suspiciously while shopping in a store or being harassed by the police. Regardless of the frequency, racial discrimination acts as a stressor in the marginalized individual's life. Racial discrimination has primary effects, where strains and hardship occur over time and day to day, or secondary effects, where negative life events happen as a result of chronic and daily exposure to racial discrimination (Ong et al., 2009). Both stressors can operate in an additive fashion and increase psychological distress.

A study assessed how racial discrimination was related to mental health outcomes using a sample consisting of 174 African American graduate students who were asked to complete daily, online diaries over a two-week span (Ong et al., 2009). The diaries were completed during the same time period, and self-report questionnaires were used to obtain additional information. The authors found that racial discrimination among African Americans has a detrimental effect on well-being and this is demonstrated across several psychological outcomes. The stress and consequences associated with racial discrimination multiply to create other stresses across a variety of domains such as family, health, and finances. Therefore, the variability in how individuals are impacted by racial discrimination may lie in the different configurations of primary and secondary stressors the person is exposed to (Ong et al., 2009).

Disparities in the Prevalence and Course of Psychiatric Disorders

Groups of African Descent

Major depressive disorder (MDD) is a common psychiatric disorder in the United States (U.S.), that is the fourth leading cause of disability

worldwide (Murray & Lopez, 1996a), and is projected to be the second leading cause of disability worldwide by 2020 (Murray & Lopez, 1996b). As of 2016, the prevalence of MDD in US adults was 6.7%, or 16.2 million adults (National Institute of Mental Health, 2017). In the U.S., its economic burden was estimated to be \$83 billion in the year 2000 (Williams et al., 2007). Research has indicated that the relationship between MDD and race or ethnicity is complex.

Williams et al. (2007) investigated the prevalence and course of MDD in Blacks and Whites living in the U.S. The study employed a national household probability sample ($N = 6082$) of African Americans, Caribbean blacks, and non-Hispanic whites between February of 2001 and June of 2003. While they found 12-month estimate of MDD was similar across groups, the lifetime prevalence was highest for non-Hispanic Whites. But for the course of MDD, Williams et al. (2007) found the chronicity of MDD was worse for both African Americans and Caribbean blacks compared to Whites, and that both Black groups were more likely than Whites to rate their depression as disabling, severe, or very severe. Furthermore, less than half of African Americans, and less than a quarter of Caribbean blacks received any form of therapy for MDD (Williams et al., 2007). These findings suggest that while Blacks may be less likely than Whites to have a depressive episode in their lifetime, any given episode will be more likely to be disabling and go untreated.

The relationship between race and psychosis is also complex. There is a long-standing supposition that individuals of African descent, or Blacks, are at an increased risk for developing psychotic spectrum disorders, and in particular schizophrenia (Barnes, 2004; Schwartz & Blankenship, 2014). Much of the research supporting this supposition has emanated from Europe. For example, studies conducted in the United Kingdom have consistently found higher risk for schizophrenia, as high as an 18-fold increase, among Black immigrants compare to ethnically white Brits (Anglin, Lee, Yang, Lo, & Opler, 2010). But studies conducted on Blacks who reside in their countries of origin, such as

Jamaica and Trinidad and Tobago, and various countries in Africa, provide weak to no evidence that schizophrenia and psychosis are elevated in these populations. As a result, the process of migration and the social environment have been implicated as risk factors for psychosis (Anglin et al., 2010).

In the US., results from nationally representative epidemiologic studies suggest elevation in the incidence and prevalence of psychosis among groups of African ancestry is in large part explained by the confounding of SES with race (Robins & Reiger, 1991), or by racial biases in the diagnostic process (Anglin & Malaspina, 2008). Misdiagnosis and diagnostic instability have been shown to be greater among African American patients compared to other racial groups (Anglin & Malaspina, 2008). This rate of misdiagnosis has been attributed to factors such as social distance, clinician bias, differential adherence to diagnostic criteria, and differential symptoms endorsement among Black patients (Whaley, 2001). A study by Strakowski and colleagues at the University of Cincinnati (Strakowski et al., 1996) found that African Americans were more likely than Caucasians to receive a diagnosis of schizophrenia and less likely to receive a diagnosis of psychotic depression. This difference held even though the rate of current depressive episodes reported by the Caucasian and African American samples was very similar (Strakowski, Flaum, et al., 1996).

In a different sample of 100 patients who met DSM-III-R criteria for bipolar disorder or schizoaffective disorder, bipolar type, with current psychotic mania, Strakowski, Mcelroy, Keck, and West (1996) compared clinical diagnoses with research diagnoses on the same patients. Participants were given research diagnoses using the Structured Clinical Interview for DSM-III-R (SCID-P), and clinical diagnoses from the Psychiatric Emergency Service at the time of admission. They found that there was no difference in research SCID diagnoses between the African American and Caucasian patients with psychotic mania. However, there was a difference in the clinical diagnoses, where African Americans were more likely to have received a

clinical diagnosis other than bipolar or schizoaffective disorder. The authors concluded that clinicians may have more difficulty identifying mania in any patient with psychosis, and that this difficulty was more apparent among African American patients (Strakowski, Mcelroy, et al., 1996).

Other US-based studies found a disparity between African Americans and Whites in the prevalence of symptoms and disorders across the psychotic spectrum. A birth cohort study of an urban, insured US population found a twofold to threefold increase in schizophrenia for African Americans compared to non-Latino Whites (Bresnahan et al., 2007) and studies of subthreshold psychosis find racial disparities, with Blacks and Latinos exhibiting higher symptom probability and frequency than Whites (Schwartz & Blankenship, 2014).

Immigrants of Color: The Immigrant Paradox

Epidemiological studies find differences in the prevalence of psychological disorders across immigrant status (Teruya & Bazargan-Hejazi, 2013). Often termed the “immigrant paradox,” first generation immigrants tend to exhibit better health outcomes than US born second-generation immigrants and Whites despite generally having less access to socioeconomic resources (Alcántara, Estevez, & Alegría, 2017). Acculturation which is defined as “the changes that take place as a result of contact with culturally dissimilar people, groups, and social influences” (Gibson, 2001, p. 19) may have an impact on health outcomes and offer protective factors. Research studies have shown that greater degrees of acculturation are associated with poorer health outcomes (Alegría et al., 2004; Alegría et al., 2008). As an immigrant’s exposure to mainstream US culture increases, more psychological difficulties are experienced. It has been argued in the literature that a lesser degree of acculturation may be a protective factor. For example, one study found that Hispanic adolescents who spoke mostly Spanish and engaged in Hispanic cultural practices (as a measurement of

acculturation) were less likely to use drugs and alcohol, and more likely to be physically active (an indicator of healthy behaviors) (Alegría et al., 2008).

Latino immigrants reported decreased rates of substance use and anxiety disorder when compared to US born Latinos, and non-Latino white individuals (Alegría et al., 2008). In order to study this discrepancy, Alegría and colleagues combined and examined data from the National Latino and Asian American Study (NLAAS) and the National Comorbidity Survey Replication (NCS-R), two of the largest nationally representative samples of psychiatric information. Data was collected through interviews conducted either in Spanish or in English and analyzed to generate a lifetime and 12-month diagnosis using DSM-IV and ICD-10 diagnostic systems. Even when controlling for age and gender, the authors still found differences between Latino and non-Latino White subjects, where US-born non-Latino white subjects reported higher rates of disorders compared with US-born Latino subjects (Alegría et al., 2008).

When disaggregated into ethnic groups, the authors found significant differences in rates of psychiatric disorders. The rate for lifetime disorder was highest among Puerto Ricans (37.4%), followed by Mexican subjects (29.5%), Cuban subjects (28.2%), and other Latino subjects (27%). While rates of depressive disorders were not found to be significantly different between Latino groups, the rate of substance use among Puerto Ricans (13.8%) was nearly twice the rate among Cuban participants (6.6%).

When considering the aggregated Latino category, the authors found evidence in support of the immigrant paradox. US-born Latino subjects had significantly higher risk than immigrant Latino subjects for: MDD, any depressive disorder, social phobia, posttraumatic stress disorder (PTSD), any anxiety disorder, alcohol dependence and abuse, and drug dependence and abuse. Among Mexicans, the immigrant paradox consistently holds across mood, anxiety, and substance disorders while it is only evident among Cubans and other Latinos for substance disorders (Alegría et al., 2008).

A study of the prevalence of mental health disorders among a nationally representative sample of Asians found that US born Asians had the highest rates of any disorder (i.e., depression, anxiety, substance use) compared to non-US born Asians (Takeuchi, Alegría, Jackson, & Williams, 2007). However, indicators of acculturation such as English proficiency, and age at migration and gender impacted the results. Proficiency in English was protective for Asian men, particularly with regards to depression and anxiety. Immigration as an adult was also a protective factor, particularly for women. Overall, the immigrant paradox was most consistent for substance use, especially in men (Alegría et al., 2004; Takeuchi et al., 2007).

The long-term psychological consequences of the process of acculturation are variable, depending on social and personal factors that exist in the society of origin, the society of settlement, and variables that exist both prior to, and arise during, the course of acculturation (Berry, 1997). Individuals begin the acculturation process with several personal factors of both demographic and social nature that influence their acculturation process (Berry, 1997). Age, for example, is known to have a direct relationship to acculturation, where individuals who immigrate at a young age are more likely to absorb the receiving country's cultures, customs, and values as compared to an individual who immigrates as an adult (Berry, 1980). Acculturation also depends on both the societies of origin and of settlement. In the society of origin, the cultural characteristics that complement the acculturation process need to be addressed to understand where the person is coming from. These characteristics will also establish cultural features for comparison with the society of settlement (Gibson, 2001). In the society of settlement, the orientation of the social environment and its citizens towards immigrants impacts an individual's exposure to discrimination in their receiving country (Gibson, 2001). In addition, whether or not the individual is an ethnic minority in the receiving country will play a role in the acculturation process. Finally, reasons for migration play an important role in the process of acculturation.

Lesbian, Gay, Bisexual, and Transgender Populations (LGBT)

United States (U.S.) and international studies consistently conclude that LGBT youth report higher rates of emotional distress, symptoms related to mood and anxiety disorders, self-harm, suicidal ideation, and suicidal behavior when compared to heterosexual youth (Russell & Fish, 2016). Members of the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community have a greater risk of facing institutionalized prejudice, social stress, exclusion, and rejection as well as homophobic hatred and violence resulting in hostile and stressful social environments that can lead to mental health problems (Meyer, 2003). A systematic review and meta-analysis were conducted to assess the prevalence of mental disorder, substance misuse, suicide, and suicidal ideation among Lesbian, Gay, and Bisexual (LGB) individuals (King et al., 2008). Results of this study revealed that the risk for depression and anxiety disorders (over a period of 12 months or a lifetime) was at least 1.5 times higher in LGB people and alcohol and other substance dependence over a 12-month period was also 1.5 times higher (King et al., 2008).

Another study investigating suicide-related characteristics by sexual orientation found that bisexual women had a nearly six-fold increased risk of lifetime suicide attempts than heterosexual women, and homosexually experienced men, defined as men who did not self-identify as LGB but reported same-sex sexual partners since age 18 years, had almost seven times higher risk of lifetime suicide attempts than heterosexual men (Blosnich, Nasuti, Mays, & Cochran, 2016). In another study conducted by Batejan and colleagues in 2015, 15 studies were reviewed describing associations between sexual orientation and non-suicidal self-injury in 7147 sexual minority and 61,701 heterosexual participants. Results showed that sexual minority adolescents and bisexuals were found to be at a particularly higher risk for non-suicidal self-injury when compared to heterosexuals (Batejan, Jarvi, & Swenson, 2015). Furthermore, disparities based on sexual orientation are also seen in purging and

binge eating disorders (Austin et al., 2009). A study conducted with the purpose of describing patterns of purging and binge eating from early through late adolescence in female and male youth across a range of sexual orientations found a higher risk of eating disordered behaviors in lesbian, gay, bisexual, and “mostly heterosexual” adolescents (Austin et al., 2009).

Similarly, suicide rates and suicidal tendencies among members of the transgender community are considerably higher compared to the general population. To determine the independent predictors of attempted suicide among transgender persons, Clements-Nolle and colleagues interviewed 392 male-to-female (MTF) and 123 female-to-male (FTM) individuals. Participants were recruited through targeted sampling, respondent-driven sampling, and agency referrals in San Francisco (Clements-Noelle, Marx, & Katz, 2006). Results revealed that the prevalence of attempted suicide was 32% with depression, and a history of substance abuse treatment, a history of forced sex, gender-based discrimination, and gender-based victimization independently associated with attempted suicide (Clements-Noelle et al., 2006).

As illustrated in the studies above, one's race, ethnicity, immigrant status, and sexual orientation are categories of group identity that have implications for mental health outcomes. African Americans are more likely to be diagnosed with psychosis than depression, a disparity that may speak to some of the biases among clinicians that requires attention (Anglin et al., 2010). In addition, experiences associated with acculturation and discrimination undermine the mental health of patients of color, and it is up to clinicians to be more open to exploring such factors that may have real implications for those who hold these group identities. In addition, despite the SES challenges faced by first generation immigrants, there seems to be cultural protective factors that clinicians should incorporate into clinical work with such patients to improve mental health outcomes. Finally, the high risk of suicide among LGBT youth must be considered when working with patients who are exploring their sexual identity. Overall, different group identities raise various

issues around the safety and overall mental health of individuals who identify with one or more of these group identities, and it is up to clinicians to be cognizant of these risk and protective factors when it comes to working with diverse patients.

Intersectionality

In thinking about individuals who have various group identities, it is important for them to consider the concept of intersectionality. As opposed to the addition of unique identities, intersections create unique issues, conflicts, and probabilities. Clinicians grapple to understand how social categories such as race, ethnicity, gender, sex, social class, sexual orientation, and many more work simultaneously to influence outcomes. For an individual, the meaning of one social identity (identifying as a woman) depends on the existence of another identity (identifying as a lesbian). How two, three, or four identities or groupings merge may not be as obvious because of differences in how an individual experiences levels of disadvantage or difference.

Intersectionality can be defined as the ways in which multiple forms of inequality or disadvantage compound to create obstacles (Crenshaw, 1995). It involves trying to understand how social categories, which have so much meaning and consequences in intergroup interactions, work simultaneously to influence outcomes. According to Crenshaw, intersectionality is not just about having multiple identities, it is related to the way societal structures make certain identities the vehicle for vulnerability, and how institutional structures play a role in the inclusion of some identities and exclusion of others. The intersection of individual identities is not compartmentalized wherein the effects are additive, this interaction of different identities creates a distinct experience when combined. Crenshaw (1995) exemplifies intersectionality by the double discrimination experienced by African American women; the simultaneous impact of both race and gender discrimination. The overlapping of racism and sexism creates a unique dynamic that leads to multiple levels of social injustice (Crenshaw, 1995).

Mahalingam and Trotman Reid (2007) characterized intersectionality in terms of the “interplay between person and social location, with particular emphasis on power relations among various social locations” (p. 45). To address issues of gender and ethnic privilege, Mahalingam and Trotman Reid (2007) organized an exchange of self-stories among African American college women and marginalized Dalit Indian women as a technique to promote intercultural understanding and examine cross-cultural boundaries. The narratives produced by these women conceptualized race and gender as structural categories and social processes rather than primarily as characteristics of individuals. This perspective contributed to a more nuanced understanding of the intersection of gender, other social identities, and the power for these marginalized groups (Mahalingam & Trotman Reid, 2007).

Two research studies by Mahalingam & Leu, and Remedios and colleagues on the intersection of race and perceptions of masculinity illustrate the complex nature of intersecting identities. One study found that members of three different ethnic groups (Black, Filipino, and Indian) strategically embraced prevailing norms of femininity in an effort to resist racial denigration (Mahalingam & Leu, 2005). Another experimental study found that when Black men were perceived as gay (presumably more feminine) participants had a less dangerous negative perception of a “black male,” resulting in a more likable first impression (Remedios, Chasteen, Rule, & Plaks, 2011).

Sinclair, Hardin, and Lowery (2006) conducted a study in which they investigated self-stereotyping in the context of multiple identities. Simultaneously run experiments examined self-stereotyping in the context of ethnic and gender identities among three samples of college students—Asian American women, European American women and men, and African American women and men—each of which is subjected to different stereotypes about math and verbal ability. The authors studied how they viewed their own ability when their gender or ethnicity was primed or made salient. Results showed that Asian American women and European Americans exhibited knowledge of

stereotyped social expectancies for their more salient identity. Specifically, Asian American women primed with gender evaluated their verbal abilities more favorably than their mathematics abilities. But when their race was primed, they evaluated their mathematics abilities more favorably than verbal abilities (Sinclair et al., 2006). This experiment suggests that self-stereotyping is mediated by the degree to which close others are perceived to endorse stereotypes as applicable to the self.

Levin, Sinclair, Venigas, and Taylor (2002) examined the combined impact of gender and ethnicity on expectations of general discrimination against oneself and one's group for African Americans, Latinos, and Whites. The double-jeopardy hypothesis states that women of color will expect to experience more discrimination than men of color, White women, and White men because they are part of both a low-status ethnic group and a low-status gender group. Alternatively, the ethnic-prominence hypothesis argues that ethnic-minority women will not differ from ethnic-minority men in their expectations of discrimination because these expectations will be influenced more by perceptions of ethnic discrimination, which they share with men of color, than by perceptions of gender discrimination (Levin et al., 2002). The researchers found that the study results were consistent with ethnic-prominence. Latina and African American women did not differ from their male counterparts in expectations of personal and group discrimination. These expectations were more informed by the women's perceptions of ethnic discrimination, which they share with men of color, than by their perceptions of gender discrimination. In contrast, perceived gender discrimination contributed to expectations of discrimination among White women, but perceived ethnic discrimination did not (Levin et al., 2002).

It is important to assess the degree to which various group identities are salient for patients and the unique dynamic created in their social world in society. In addition, understanding the unique issues, conflicts, and probabilities that arise with the intersection of multiple group iden-

ties informs how these intersections impact overall mental health, which can be used to inform treatment.

Barriers to Effective Treatment

Not only does the intersection of certain group identities create a unique dynamic that causes multiple levels of societal injustice and stigma, it also leads to group differences in treatment effectiveness and accessibility (Smedly, Stith, & Nelson, 2003; Wang, Berglund, & Kessler, 2000). When it comes to mental illness, stigma and discrimination are thought to contribute to racial and ethnic disparities in service utilization (U.S. Department of Health and Human Services, 2001). For example, ethnic minorities are less likely to seek outpatient mental health care than Caucasians, even with similar access to insurance services (McGuire & Miranda, 2008). In addition, the literature suggests that once in treatment, African Americans are more likely than Caucasians to prematurely terminate treatment (Fiscella & Sanders, 2016; McGuire & Miranda, 2008).

Access

Research has shown that differences in accessibility to services vary by ethnic or racial group based on several factors. For example, despite expressing more favorable attitudes towards mental health services, members of racial or ethnic minority groups are less likely than Caucasians to access services. African Americans have been found to utilize fewer services than Caucasians despite research that shows they are more likely to recommend professional treatment options to a hypothetical person suffering from mental health problems (Anglin, Alberti, Link, & Phelan, 2008). A nationally representative study of 583 Caucasian and 82 African American participants who responded to a vignette about a hypothetical person with major depressive disorder, schizophrenia, or a number of physical illnesses revealed an interesting pattern. While

African Americans, compared to Caucasians, were more likely to believe that a mental health professional could help individuals with schizophrenia and major depression, they were also more likely to believe that mental health problems would resolve on their own (Anglin et al., 2008). Anglin et al. (2008) concluded that African Americans' beliefs in the likelihood of remittance without professional help could undermine their more positive attitudes toward the benefits of seeking care. Therefore, belief in the effectiveness of mental health treatment may not correspond to an increase in service utilization among African Americans in the same way that this belief has implication for service utilization among the Caucasian majority (Anglin et al., 2008).

Stigma

Stigma, an important area of study within the field of mental health, also plays an important role with regards to disparities in mental health outcomes (Link & Phelan, 2001). The 2001 Surgeon General's report on mental illness highlighted stigma as a major impediment to receiving treatment and obtaining quality resources (U.S. Department of Health and Human Services, 2001). Stigma is a public health concern as it may result in an increase in the morbidity of disease. Link and Phelan (2001) adopted a comprehensive conceptualization of stigma, defining it as "elements of labeling, stereotyping, separation, status loss, and discrimination that co-occur in a power situation which then allows the components of stigma to unfold" (p. 367). They argue that stigma does not only impact those that are already ill, but also the negative attributes that our society imposes upon people with mental illness exist long before they may become patients themselves (Link & Phelan, 2001).

Stigma also has the ability to negatively affect mental health treatment-seeking patterns (Corrigan, 2004). Nationally representative research indicates that a large proportion of people with a diagnosable mental disorder and a perceived need for help do not seek help (Mojtabai,

Olfson, & Mechanic, 2002). To a large extent, culture has been found to determine whether and to what degree an illness is stigmatized. The degree of stigma attached to an illness depends on (1) the features of the illness, (2) how it is symbolically interpreted by a certain culture, and (3) what effect the illness has on the individual's social identity (Fabrega, 1991).

Stigma accompanying mental illness in Chinese society has been described as particularly damaging and pervasive (Tsang, Tam, Chan, & Cheung, 2003). A study by Kleinman described how Chinese culture plays a role in the stigmatization of individuals with Schizophrenia. According to Kleinman, social interactions in Chinese groups are organized by a strict network of social relations (*quanxi*). The maintenance of this network is dependent on the reciprocation of favors (*renqing*). Returning favors is directly tied to face (*mianzi*), which is a representation of social power. The diagnosis of schizophrenia results in 'loss of face' where the stigmatized become powerless to engage in social relationships (Yang & Kleinman, 2008). Another research study (Phelan, 2005) examined the sociological impact of the Human Genome Project, and specifically how this project affects the stigma of mental illness. Researchers interviewed 1241 participants from a number of ethnic minority groups. They found that Chinese-Americans demonstrated more socially restrictive attitudes regarding people with mental illness getting married and having children. Chinese-American participants also demonstrated more intimate social distance towards siblings of people with mental illness. Differences in attitudes towards dangerousness and desire to protect family sanctity appeared to explain why Chinese-Americans demonstrate more socially restrictive and distancing attitudes.

The acceptance of an official diagnostic label initiates two conflicting processes. It simultaneously enables treatment and care, but it also sets into motion the stigmatizing consequences of stereotyping, separation, discrimination, and power loss. "Excessive thinking" is an idiom for mental illness in the Chinese community that helps to hold stigma at bay by preserving social relations

and the moral standing of individuals. Researchers conducted four focus groups ($n = 34$) with the family members of schizophrenia outpatients. Yang et al. (2010) found that several relatives admitted that denial and fear of acknowledging mental illness motivated their use of “excessive thinking” to explain abnormal behavior. They reported that they frequently underestimated the severity of such deviance in hopes that their family member’s condition would improve. This alternate label that evokes the universal nature of the experience of these psychotic-like symptoms can lead to acceptance of the individuals and result in less stigma and better outcomes (Yang et al., 2010).

Minority stress theory (Meyer, 1995, 2003) has provided a foundational framework for understanding sexual minority mental health disparities and stigma. It suggests that sexual minorities experience distinct, chronic stressors related to their stigmatized identities, including victimization, prejudice, and discrimination. These distinct experiences, in addition to everyday stressors, compromise the mental health and well-being of LGBT people (Russell & Fish, 2016). Furthermore, the absence of institutionalized protections, biased-based bullying, and family rejection are associated with increasing these mental health vulnerabilities.

While prior research has shown that intrapersonal and interpersonal forms of stigma negatively affect the health of the stigmatized, few studies have addressed the health consequences of exposure to structural forms of stigma. To address this gap in the literature, Hatzenbuehler et al. (2014) investigated whether structural stigma, defined as living in communities with high levels of anti-gay prejudice, increases risk of premature mortality for sexual minorities. To capture the average level of anti-gay prejudice at the community level, researchers used a representative sample of US noninstitutionalized English-speaking population aged 18 and over. Results revealed that sexual minorities living in communities with high levels of anti-gay prejudice experienced a higher hazard of mortality than those living in low-prejudice communities (Hatzenbuehler et al., 2014). This result trans-

lated into a shorter life expectancy of approximately 12 years for sexual minorities living in high-prejudice communities (Hatzenbuehler et al., 2014).

The intersection of race and sexual orientation reveals how difficult it may be for LGBT people of color to expose themselves and reach out for help. Individuals who hold these group identities may be more likely to be in more distressed states when they finally make the decision to seek treatment. Stigma may impede a person’s desire to remain in treatment and so it may be necessary to address it directly to build the therapeutic alliance.

Conclusion

In reflecting back to *James*, described at the beginning of this chapter, it is important to think about both the macro and micro-level factors that may be contributing to his clinical presentation and that may shape the development of the therapeutic alliance. As a second-generation immigrant, bisexual, man of color, he may face stigma and discrimination in society as well as within his own family and community. Due to the stigma of mental health treatment seeking, he may not have shared his decision to seek treatment with others. His odd perceptual experiences need not be clinical psychosis and may be a component of the depression. While these are all possibilities and not forgone conclusions, knowledge about the epidemiologic research on these group identities and their intersections enriches the clinicians’ perspective and shapes a different way to be curious about patients.

In addition, group identity dynamics within the therapeutic dyad are often a reflection of those within the larger society. For example, racial microaggressions have been found to impede the development of the therapeutic alliance in cross-racial dyads (Constantine & Kwan, 2003). Microaggressions can have a negative impact on the relationship between the clinician and the patient and take a myriad of forms in the clinical setting. For example, avoiding the discussion of

race with a patient, or colorblindness, can be interpreted as a microinvalidation. Additionally, the white therapist may make self-righteous assertions of being non-racist; attempting to conceal unexamined racism by identifying instances in which they avow a connection with, or allegiance to, Black people or things (Constantine & Kwan, 2003; Gelso & Hayes, 1998; Sue, Zane, Hall, & Berger, 2009; Williams & Fauth, 2004). Lastly, heterosexual therapists may make assumptions about their client's sexual orientation and gender of the partner (e.g., asking a man about his girlfriend). Taking into account the concepts that have been discussed throughout this chapter, what additional questions would you ask James during intake that you might not have thought of before?

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